



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PETERSON REGIONAL MEDICAL CENTER
551 HILL COUNTRY DR
KERRVILLE TX 78028

DWC Claim #:

Injured Employee:

Date of Injury:

Employer Name:

Insurance Carrier #:

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-0767-01

MFDR Date Received

NOVEMBER 5, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was sent through P2P link it arrived at P2P on 5/4/10 and was submitted to Texas Mutual on 5/10/10. I have enclosed a copy of the original bill, your explanation of benefits, med records and proof of timely filing from P2P."

Amount in Dispute: \$81.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to the requestor for medical fee dispute resolution. The *Notice of Medical Fee Dispute* was placed in the carrier representative box on November 18, 2010 and signed by Travis Kelley on November 19, 2010.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 14, 2010	Outpatient Hospital Services	\$81.00	\$81.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement for guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated October 13, 2010

- W4 – No additional reimbursement allowed after review of appeal/reconsideration.

- 29 – The time limit for filing has expired.
- 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05.
- 891 – No additional payment after reconsideration.

Issues

1. Did the Requestor submit the bill in accordance with with 28 Texas Administrative Code §133.20?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. Review of the documentation finds that the Requestor submitted the original bill timely and in accordance with 28 Texas Administrative Code §133.20. Therefore, the disputed service will be reviewed in accordance with Division rules and the Texas Labor Code.
2. Review of the submitted documentation finds no information to support a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 99281 has a status indicate of V, which denotes a clinic or emergency department visit paid under Outpatient Prospective Payment System (OPPS). This service is classified under APC 0609, which, per OPPS Addendum A, has a payment rate of \$53.16. This amount multiplied by 60% yields an unadjusted labor-related amount of \$31.90. This amount multiplied by the annual wage index for this facility of 0.8913 yields an adjusted labor-related amount of \$28.43. The non-labor related portion is 40% of the APC rate or \$21.26. The sum of the labor and non-labor related amounts is \$49.69. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this service is \$49.69. This amount multiplied by 200% yields a MAR of \$99.39.
5. The total recommended payment for the services in dispute is \$99.39. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$99.39. The requestor is seeking \$81.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$81.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$81.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ August 22, 2012 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.